NOTICE OF ACTION AND RIGHT TO REQUEST A STATE HEARING ON INTERIM ASSISTANCE

State No.:
County No.:
Worker No.:
District:
Date:
Case Name:
Interpreter Needed: _____ (Language) _____ (Dialect)

This office received on _____ a Supplemental Security Income/State Supplementary Program (SSI/SSP) payment for you in the amount of $ _____ , for the period _____ through _____. As per your agreement, we are sending you the balance of $_____ after deducting the amount of $_____ , to repay the amount of assistance you received from Interim Assistance for that same period while Social Security Administration (SSA) completed the work on your eligibility determination for SSI/SSP benefits.

SSI/SSP PAYMENT

If you disagree with the amount of the SSI/SSP payment of $_____, contact your local Social Security Office. The amount of the total SSI/SSP payment is subject to the SSA appeal process. A request for reconsideration must be filed within 60 days after the date the notice of the initial determination is received.

INTERIM ASSISTANCE PAYMENT

If you disagree with the amount of Interim Assistance withheld from your SSI/SSP payment or you contend that we did not send you the balance, if any, as shown above within the 10 working days, please contact the State Department of Social Services. This action is subject to the state fair hearing provision described on the reverse side of this form.

COMMENTS:

The law and/or regulations governing this action are:

Department of Social Services Eligibility and Assistance Standards Manual Section 46-337

If you have any questions please contact me.

County/State Representative		Agency
Telephone	Date:	

YOUR HEARING RIGHTS

To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free:	1-800-952-5253
If you are deaf and use TDD call:	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office of welfare rights group.

Other Information

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the State Hearing Officer. You have a right to examine the materials that make up the file. Any information you provide may be shared with the departments whose action you are appealing and the U.S. Department of Health and Human Services. Authority: W&IC 10950.

I will bring this person to the hearing to help me
(name and address, if known):

_____

_____

_____

I need an interpreter at no cost
to me. My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature: _____

Date: _____

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to :

You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by_____
about the interim assistance said department deducted from my SSI/SSP payment.

Here's why: _____

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